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The Decline of the Community Care Model
The Rise of the Rehab Riviera(s)

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The Decline of the Community Care Model and the Rise of the Rehab Riviera(s)

By Christi Hogin*

In certain respects, this is the story of a collision between a good policy and unintended consequences.

Good policy: The strength of the state's residential communities can be leveraged to provide beneficial environments for long term care and promote integration of persons with disabilities into communities throughout California.

Historically, many disabled adults and children ended up in institutional programs even though, with just basic care and supervision, they would function well within the community. This fact gave rise to popular support (among service providers, academics, insurers, patient advocates and politicians) for an alternative to the medical model of long term care for the disabled. The medical model relied on institutions to provide care. The alternative is the social model, which relies on community care facilities. Under the social model of service, relatively high functioning disabled people live productively together as a single housekeeping unit (AKA a "family") with a minimum of supervision or assistance. The Legislature expressed a statewide interest in integrating such facilities into communities and residential neighborhoods across California. It would become the policy of the state to facilitate the social model by regulating the quality of social model programs and by protecting their ability to operate in residential neighborhoods. This policy was realized in legislation, starting with the Community Care Facilities Act.

Here is the history of the Community Care Facilities Act in the government's own words:

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In 1973, the Legislature enacted the Community Care Facilities Act to be administered by the Department of Health. The purpose of the Act was to establish a statewide system of community care (separate from health care) for persons with mental and developmental disabilities, and socially dependent children and adults. The Act required the Department of Health, together with care providers (Advisory Committee on Community Care Facilities), to jointly establish new regulations for licensing non-medical out-of-home care facilities.

In 1978, the Legislature established within the Health and Welfare Agency the Departments of Health Care Services, Mental Health, Developmental Services, Social Services, Alcohol and Drug Programs, and the Office of Statewide Health Planning and Development. The Department of Health Services was reorganized and retained licensing responsibility for all Health Care Facilities (medical models/institutional settings) and licensing responsibilities for all Community Care Facilities (social models/residential settings) were transferred to the new California Department of Social Services (CDSS). The Community Care Licensing (CCL) Program along with several programs from the former Department of Benefit Payments were combined to form the current Department of Social Services.

Community care was originally envisioned as a normalizing and least restrictive environment for persons needing basic care and supervision that would assist them in performance of the activities of daily living. The children and adults placed in such settings were envisioned as requiring little more than a healthful safe and supportive environment.

Today the CCL Program remains a Division within CDSS. However the nature of community care has changed significantly and now includes care for persons whose needs require the management of severe behavior adjustment problems, serious mental disorders, and significant medical needs. In order to give emphasis to the different populations served the CCL Program is now governed by three separate licensing Acts and a fourth statute that was enacted in 1990.[1]

Group homes and other social model programs are available for foster children, Alzheimer patients, seniors generally, mentally or developmentally disabled adults or children or any similar group. The key is that the programs do not provide medical services but do provide supervision. These facilities are licensed by the state.

[1]http://www.ccld.ca.gov/PG521.htm

Unintended consequences (and the latent defect of the policy): The dominant idea behind the implementation of the policy is that small groups of disabled persons would live as families among families in California's residential neighborhoods, nestled in the strength and comfort of the community.

To assure that this policy is implemented as envisioned, local governments were prohibited from treating these licensed group homes differently than any other family or single family residential use. As the policy makers, planners, and government problem-solvers considered how to encourage the success of the social model and prevent creation of group home ghettos, which might result if local governments used their zoning power to preclude group homes from some single family zones, the policy architects never imagined how the policy would fare in the face of Big Business.[2]

Social model group homes were not seen as a source of great income. Some operators were making a profit, sure; but no one considered the possibility that the businesses would become so lucrative that they would quickly out value the homes in the neighborhoods in which they were situated. Even if they had been seen that way, the success of the business was not relevant to the policy. Certainly, the businesses that provide these services must be successful in order to sustain the social model as a viable alternative to the medical model. Indeed, in response to the burst of the housing bubble, more than a few homes were spared from foreclosure by repurposing the home as a sober living home.

[2]A word about Big Business Rehab. Estimates of the annual revenue from Malibu's rehab facilities alone is in the hundreds of millions of dollars. Malibu has a population of about 13,000. These rehab facilities have commandeered the residential neighborhoods to create a highly profitable Rehab Riviera. One of the common complaints from residents is that these are functionally businesses operating in residential neighborhoods. As discussed later in this paper, state law protects the disabled patients from housing discrimination and the service providers – the good ones and the profiteers alike – cloak their business interests in the protections against housing discrimination. One easy compromise could be borrowed from the Community Care Act's requirement that foster homes not be for-profit businesses: "Private foster family agencies shall be organized and operated on a nonprofit basis." H&S Code §1502(a)(4). This seems fair. Businesses can operate in the commercial zones (and maybe the law can preempt excluding rehabs from commercial zones) but only non-profit enterprises would be afforded special protection in the residential zones.

But the complete preemption of local zoning authority is a latent defect in the policy. The purpose of the policy is to integrate group homes into existing residential neighborhoods. The Big Business of alcohol and drug recovery has resulted in operators buying multiple properties on the same residential blocks, creating multi-parcel campuses and integrated facilities serving dozens of people. These facilities overwhelm the neighborhoods in which they operate. Ironically, the law that these facilities hide behind to prevent local regulation assumes the existence of the residential neighborhood. Yet these mega-facilities become the defining feature in some neighborhoods.

There is an obvious (and ironic) solution but it is legally hard to access. Distancing requirements are a tried and true planning tool to avoid a particular use from changing the character of a neighborhood. That is the obvious part. The irony is that, by allowing the exercise of the local zoning authority, local governments will preserve the very neighborhoods that the social model depends on to succeed. Distancing requirements *both* respond to the biggest concern of local government *and* advance state policy.[3]

That's the big picture. Next this paper looks at the drug and alcohol rehab/recovery facilities and the morass of laws that stand in the path of the obvious solution.

Residential Alcohol and Drug Recovery Facility Types

There are three types of residential facilities that accommodate recovering alcoholics and drug addicts.[4] Two of the three types of facilities must be licensed by the State:

1. **Community Care Facilities** [Health and Safety Code ("H&S Code") §1500 et seq.]. A Community Care Facility is defined as "any facility, place, or building that is maintained and operated to provide nonmedical residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults,

[3] Note that courts have been skeptical of the anti-clustering justifications raised by cities in various cases. However, these cases have largely arisen in purely theoretical contexts. As the unregulatable uses cluster and create concrete examples, cities are able to produce more sound evidentiary records of the adverse effects of clustering. Don't give up.

[4] Facilities that provide medical services are not residential uses and may be prohibited from residential zones. Also note that licensed Community Care Facilities that serve seven or more patients must be treated exactly the same as a *multifamily* residential use and cannot be defined as a "boarding house." They may be prohibited from the single family residential zones.

including, but not limited to, the physically handicapped, mentally impaired, incompetent persons, and abused or neglected children."[5] Recovery houses that are unlicensed, nonmedical and unsupervised and licensed ADP treatment facilities both are excluded from this definition.[6] Alcohol and drug treatment facilities for adolescents are governed by the Community Care Facilities Act.

2. **Alcohol and Drug Program** ("ADP") treatment facilities (H&S Code §11834.01 et seq.). An ADP treatment facility is "any premises, place, or building that provides 24-hour residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services." These facilities must provide at least one of the following nonmedical services: recovery services; treatment services; detoxification services.[7] They may not provide medical services.

State law preempts cities from regulating ADP/Community Care facilities any differently than a single family home if the ADP facility (supervised or unsupervised) serves 6 or fewer patients[8] or the licensed Community Care Facility (supervised) serves 6 or fewer.[9] That means that these facilities located in a house in the single-family zone cannot be required to provide more onsite parking or be prohibited from having their residents smoke outside or be required to have all occupants be on a single lease or to get a business license. The same *and no more* rules for parking, smoking, renting, or any other development standard or use restriction that apply to single family homes occupied by other housekeeping units apply to these facilities.

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[5]The Community Care Facilities Act defines a "residential facility" as "any family home, group care facility, or similar facility determined by the director, for 24-hour nonmedical care of persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual." H&S Code section 1502(a)(1). Further, the Act specifies that "residential facilities" serving six or fewer persons shall be considered a residential use of property. The residents and operators are to be considered a family for the purposes of any law or zoning ordinance. H&S Code section 1566.3. However, section 1566.1 of the H&S Code implies that one needs a license from the State in order to invoke the provisions of Art. 7 (which includes the preemption of local regulation for residential facilities).

[6] H&S Code §1505(i),(j)

[7] Such services may include 12-step program meetings and counseling, among others.

[8]H&S Code §11834.23

[9]H&S Code §1566.3

"Sober living environments" is the third type of facility. This is an amorphous category of facilities not subject to the same requirements and standards as licensed Community Care Facilities and ADP treatment facilities. These are unsupervised, unlicensed facilities. The legal constraints on the regulation of sober living houses is different (and less clear) than the express statutory preemption for the licensed ADPs and Community Care facilities.

Persons recovering from drug and/or alcohol addiction are disabled for the purposes of the federal Fair Housing Act (FHAA) and therefore protected from housing discrimination.[10] Recovery from addiction is also a disability under the ADA; together, the FHAA and ADA prevent local governments from enforcing zoning ordinances that impact recovery facilities for handicapped individuals different than non-handicapped residential uses in the same zone.[11] However, a City may treat such facilities differently if the City can prove that the treatment is necessary to further a legitimate government interest.[12] Further, because sober living home residents are handicapped, a City must grant requests for reasonable accommodation by waiving enforcement, unless the City proves that a waiver would impose an undue burden on the City and undermine the basic purpose of the ordinance.[13] This is intended to be a high standard that discourages differential treatment except where proven necessary.

The FHAA prohibits local governments, among other things, from establishing a bedroom/per occupant rule,[14] imposing distance requirements between facilities or prohibiting commercial operators from running sober living facilities in residential neighborhoods. Likewise, requiring a sober living home to obtain a CUP, business license or home occupation permit would impose requirements on the residences of "handicapped" persons that are not imposed on other residences.

[10] 42 U.S.C. §3602(h) (however, current, illegal use of or addiction to a controlled substance is not a handicap under the FHA); *Pacific Shores Properties*, 730 F.3d 1142 (9th Cir. 2013) (rehearing en banc denied Mar. 4, 2014).
[11] 42 U.S.C. §3604(f); *Pacific Shores Properties*, 730 F.3d at 1157.
[12] *McDonnell Douglas Corp. v. Green*, 411 U.S. 792.
[13] *Oxford House-C v. City of St. Louis*, 77 F.3d 249 (8th Cir. 1996) (however, a group home's refusal to seek a variance precludes a claim for failure to accommodate).
[14] Per-occupant requirements applied equally to all residential uses within the same zone are valid under the FHA. *See, e.g., Oxford House-C v. City of St. Louis*, 77 F.3d 249 (upholding as valid an eight-person restriction).

A claim of discrimination against a city over these types of regulations may challenge the ordinance on its face or as applied to a specific circumstance. Whether a facial or as-applied challenge, there are three legal categories of discrimination. Understanding these is the key to drafting an ordinance that is legal and making a record to support the legal defense of the regulation:

1. Discriminatory treatment is where a protected class of persons (the disabled) is subjected to different treatment under a law. Discriminatory treatment is illegal unless the different treatment benefits the protected class or responds to legitimate safety concerns. Consequently, the ability of a city to defend a regulation rest largely on its ability to make an evidentiary record to prove beneficial effects or safety concerns. A facially neutral regulation (does not treat protected class of persons differently) may still be challenged as discriminatory treatment if evidence establishes that the intent of the statute is discriminatory.[15] Regulations must be justified by legitimate, nondiscriminatory non-pretextual reasons.

2. Disparate impact is where a regulation has a significantly different and adverse impact on a protected class.

3. Reasonable accommodation of rules, practices, policies and services for persons of a protected class is required and failure to make a reasonable accommodation constitutes discrimination. An accommodation is reasonable unless it requires a fundamental alteration in zoning regulations or imposes an undue financial or administrative burden.

Relying on court cases that have interpreted the FHAA, the Legislative Counsel[16] has opined that the state and local government may not regulate "sober living homes" through dispersal or distance requirements, CUPs, business licenses or zoning restrictions unless the regulation benefits the protected class or responds to legitimate safety concerns raised by individuals affected rather than being based on stereotypes.[17] The underlined

[15] Be aware that courts have attributed discriminatory statements made by residents to the city decisionmakers as evidence of a discriminatory motive. City Councils must be mindful to expressly delineate the interests they are considering and those they are rejecting.

[16] The Office of Legislative Counsel is a nonpartisan public agency that drafts legislative proposals, prepares legal opinions, and provides other confidential legal services to the Legislature and others.

[17] The legal test to determine whether an ordinance that subjects a protected class to different treatment – e.g. sober living homes must have CUPs to operate but other homes do not -- is

provision seems to me to be the place where local and state interests intersect. As discussed above, the policy underlying the state laws is to provide care in a residential setting. Maintenance of the integrity of residential neighborhoods is necessary to provide that setting.

Legal obstacles still impede efforts aimed at preventing overcrowding.

According to the Attorney General, Enough Is Not Enough: Overconcentration of Licensed Facilities

The Legislature codified the state's "policy" that "each county and city shall permit and encourage the development of sufficient numbers and types of alcoholism or drug abuse recovery or treatment facilities as are commensurate with local need."[18] The policy implies that the number of facilities may be limited to the number sufficient to serve local need. In 2007, Senator Tom Harman asked the California Attorney General[19] two questions: 1) may a State license be denied to avoid an overconcentration of treatment facilities in a particular locality?; and 2) may a city may limit the number of treatment facilities within its jurisdiction to prevent an overconcentration of such facilities? To both questions the Attorney General answered no.

The state won't deny a permit due to overconcentration. The Attorney General concluded that the "policy articulated" (as quoted above) "does not afford a basis for denying a license where the applicant meets all basic qualifications for the license" because "the Legislature has not given the Department any authority to consider the number of treatment facilities in a particular area when granting, suspending, or revoking a license to operate a treatment facility."[20]

(..continued)
discriminatory in violation of the Fair Housing Act depends on the government's ability to establish that the restriction benefits the class or responds to legitimate safety concerns. *Community House, Inc.v. City of Boise* (9th Cir. 2007) 490 F.3d 1041, 1050.

[18]H&S Code 11834.20

[19] Opinions of the Attorney General are entitled to considerable weight, however, they are not binding on the courts. *City of Long Beach v. Department of Industrial Relations* (2004) 34 Cal.4th 942, 952. Although Attorney General opinions are particularly persuasive when interpreting a statute, less weight is afforded when case authority also interprets the statute at issue. *Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.* (2002) 100 Cal.App.4th 1066, 1075.

[20] 90 Ops. Cal. Atty Gen. 109 (No. 07-601).

Notwithstanding the state's express written policy only to require cities to permit enough alcohol and drug commensurate with "local need," the Attorney General reads the statute to essentially require issuance of permits to all eligible applicants without regard to the number of facilities in the area, whether local need is already met or if there is evidence of local saturation of such facilities. Here are the portions of the statute that form the basis of the AG's analysis.

H&S Code Section 11834.01 states in part:

> The department has the sole authority in state government to license adult alcoholism or drug abuse recovery or treatment facilities.
>
> (a) In administering this chapter, the department shall issue new licenses for a period of two years to those programs that meet the criteria for licensure set forth in Section 11834.03.

H& S Code Section 11834.03, in turn, provides:

> Any person or entity applying for licensure shall file with the department, on forms provided by the department, all of the following:
>
> (a) A completed written application for licensure.
>
> (b) A fire clearance approved by the State Fire Marshal or local fire enforcement officer.
>
> (c) A licensure fee, established in accordance with Chapter 7.3 (commencing with Section 11833.01).

As the AG sees it, each licensure applicant must complete an application form, obtain a fire clearance, and pay a fee to the Department.[21] Sections 11834.01 and 11834.03 provide no authority for the Department to deny a license because the community already has an overconcentration of such facilities.

To compare, in the Community Care Facilities Act, the Legislature articulated a substantially more balanced policy statement and opportunity for implementation. There,

[21] See also § 11834.09, subd. (b)

the policy is "to prevent overconcentration of residential care facilities that impair the integrity of residential neighborhoods."[22] To avoid overconcentration of these facilities, the State "shall deny" a new license if approval would result in overconcentration.[23] In addition, cities are afforded an opportunity to show conditions of overconcentration before an application is approved. Cities must receive written notice that a facility is proposed to be located in the city; and "any city or county may request denial of the license… on the basis of overconcentration of residential care facilities."[24] Under the Community Care Facilities Act, "overconcentration" exists when two facilities are located within 300 feet of one another.[25]

The law governing ADPs has no similar authority for cities to receive notice of and provide input into the licensing of an ADP treatment facility; and, according to the Attorney General, if "the Legislature wishes to grant a similar authorization when the [ADP] licenses the treatment facilities in question, it knows how to do so."[26] Therefore, the state "may not deny an application for licensure or suspend or revoke the license of a treatment facility because the particular community already has more than a sufficient number of treatment facilities to meet the local need."[27] With that conclusion, the AG relegated the Legislature's the policy reference to consideration of local need in approving ADP treatment facility licenses to the status of empty promise.

Cities probably can't impose regulations to prevent overconcentration of licensed facilities either. In answering Senator Harman's second question, the Attorney General opined that a city may not limit the establishment of an ADP facility serving six or fewer persons to address overconcentration because such a limitation would be in conflict with Health & Safety Code §11834.23 and thus preempted by state law. Section 11834.23 prohibits cities from treating ADP facilities treating six or fewer persons differently than any other single family residence and requires that the residents and operators be treated as a family for zoning purposes. Specifically, the Attorney General determined that a hypothetical ordinance authorizing a city to prohibit the operation of a new ADP treatment facility within 500 feet of an existing facility would be preempted by state law.

[22] H&S Code §1520.5(a).
[23] H&S Code §1520.5(a)
[24] H&S Code §1520.5(d)
[25] H&S Code §1520.5(b)
[26] 90 Ops. Cal. Atty Gen. 109 at 5 (No. 07-601).
[27] *Id.*

The Unlicensed Sober Living Home: Nondiscriminatory Limits Overconcentration and Distance Issues Related to Unlicensed Facilities

Prior to the Ninth Circuit Court of Appeals' September 2013 opinion in *Pacific Shores Properties, LLC v. City of Newport Beach* (Pacific Shores), some jurisdictions adopted zoning ordinances requiring sober living facilities to obtain conditional use permits and/or restricting their location to specific areas. These regulations applied only to unlicensed group homes and therefore were not preempted by any licensing statute. These sober living homes are the third category of recovery facilities described above and the key legal constraint on any regulation affecting sober living homes is that it cannot discriminate against the disabled.

In *Pacific Shores*, several sober living homes challenged the City's moratoria preventing new sober living homes from opening and a 2008 ordinance intended to address an influx of sober living homes in the City of Newport Beach. The Newport Beach ordinance found its way to the federal appeals court. The trial court granted summary judgment in favor of the city basically finding that the challenged ordinance was neutral on its face and was not discriminatory. The Ninth Circuit reversed and ordered the trial court to hold a trial to determine whether the ordinance violated the anti-discrimination laws, concluding that – even though the ordinance appeared neutral on its face -- the actions surrounding adoption of Newport Beach's ordinance created a factual question about whether the City adopted its ordinance with an intent to discriminate against disabled persons in violation of the federal Fair Housing Act ("FHA"), the Americans with Disabilities Act ("ADA"), and the U.S. constitution's Equal Protection Clause.

According to the Court, the ordinance "had the practical effect of prohibiting new group homes from opening in most residential zones" in the City.[28] The Court recognizes that the City's actions were in response to resident complaints ("a number of residents of the City launched a campaign to restrict or eliminate group homes in their neighborhoods"), after the City of "about 80,000 residents" found itself home to "73 group homes, 48 of which were licensed treatment facilities and 25 of which were unlicensed sober houses."[29]

Newport Beach re-classified unlicensed group homes from "single housekeeping units," which could freely locate throughout residential zones, to "residential care

[28] *Pacific Shores*, 730 F.3d at 1147
[29] *Id.* at 1148

facilities," which were prohibited from locating in most residential zones unless a "special use permit" was issued. Existing facilities were required to apply for a special use permit within 90 days of the ordinance's enactment and were required to close if a permit were not granted. Enforcement of the ordinance resulted in the actual or pending closure of about one third of the group homes in Newport Beach and prevented the opening of any new group homes. The Court noted that approval of a new group home would have been "difficult" because "only 33 out of 16,811 residential parcels in the City [were] possible sites for a new group home" under the ordinance.[30]

In reversing the trial court's summary judgment in favor of the City, the Ninth Circuit determined that "the circumstances surrounding the enactment of the ordinance compel the conclusion that the Plaintiffs have raised a triable issue of fact as to whether the ordinance was motivated by the desire to discriminate against the disabled."[31] The "circumstances" included, among other things: 1) a City Council Member's promise that the ordinance would reduce the number of group homes, 2) the City's firing and replacing a law firm that advised that an ordinance directed solely at group homes would be vulnerable to discrimination claims, and 3) various "procedural irregularities." Accordingly, the discrimination claims under the federal Fair Housing Act, Americans with Disabilities Act, and Equal Protection Clause, including a claim for damages resulting from emotional distress, were remanded to the trial court.

Just before Thanksgiving 2013, a rare event occurred in the litigation. Appeals are heard by three-judge panels. There is a procedure by which the parties or members of the court itself may request an *en banc* hearing; in the Ninth Circuit, that means that the case would be re-heard before an 11-judge panel (randomly selected from among the 29 Justices in the Ninth Circuit). A justice of the court requested the parties submit briefs arguing whether the case should be heard *en banc*. Four months later, *en banc* review of the decision was denied. However, five justices joined in a 15-page dissenting opinion, arguing that the three-judge panel's decision should not be allowed to stand because it departs from existing law in a significant respect. Generally speaking, courts do not pry into the minds of councilmembers to determine whether an ordinance is discriminatory. Instead, if an ordinance is neutral on its face, it would withstand a "facial challenge," absent other evidence that the facially neutral ordinance was a pretext for discrimination.

[30] *Id.* at 1155, n. 12
[31] *Id.* at 1162

The dissenting Justices were alarmed by the willingness of the majority to invalidate a legislative act based on inferences of nefarious motive.[32]

Presumably, Newport Beach will seek United States Supreme Court review. In the meantime, mindful of the statutes and court decisions protecting recovering alcoholics and drug addicts from housing discrimination, cities interested in addressing the Big Business Rehab uses that threaten the character of residential neighborhoods (which are essential to successful social model programs) have begun to organize to address the latent defects in the state statutes. BE SURE TO CHECK OUT THE GROUP HOME PAGE IN HOT ISSUES SECTION OF THE LEAGUE OF CALIFORNIA CITIES WEBSITE: http://www.cacities.org/Policy-Advocacy/Hot-Issues/Group-Homes

To achieve appropriate balance, preserve the residential neighborhoods and promote the state's interests, cities should advocate for these statutory changes:

1. State law should be amended to allow local governments to impose reasonable distancing requirements between licensed group homes. This authority would secure the character of residential neighborhoods to the benefit of both the community and the state policy. These regulations *benefit* the protected class of disabled persons and therefore are permitted under the Fair Housing Act Amendments of 1988;

2. Residential neighborhoods should not be open for business. State law requires foster care facilities to be non-profit. H&S Code § 1502(a)(4). Similarly, any sober living home located in a residential zone and taking advantage of state law preemption to allow it to operate should be restricted to non-profit enterprises. For-profit programs can operate in commercial zones, where businesses are accommodated.

3. Cities should be afforded the same notice for applications for an ADP facility as they receive for applications for Community Care Facilities and an ADP facility licensure application should be subject to denial due to overconcentration in the same manner as are Community Care Facilities.

4. Expressly allow cities to impose distancing requirements on group homes where to do so would avoid overconcentration, preserving the residential character of the neighborhood to the benefit of the FHAA protected class.

[32]*Pacific Shores Properties, LLC v. City of Newport Beach*, 2014 WL 843218 (9th Cir. Mar. 4, 2014)(NO. 11-55460, 11-55461)